

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Prince George's</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hyattsville</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Prince Frederick</i>	LENGTH OF STAY (In this place)	STREET ADDRESS (If rural give location)	<i>16152</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Bryan</i>	(Middle) <i>Heith</i>	(Last) <i>Bell</i>	DATE OF DEATH: <i>July 21 1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>July 20 1955</i>
9. AGE last birthday: <i>16</i> yrs. <i>5</i> months <i>16</i> days <i>5</i> hours <i>5</i> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Carl Donald Bell</i>		14. MOTHER'S MAIDEN NAME: <i>Lary Virginia Hasenmiller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Mary Bell - Hyattsville Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Premature</i>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/20</i> , 1955, to <i>7/21</i> , 1955, that I last saw the deceased alive on <i>7/21</i> , 1955, and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>[Signature]</i>		DATE SIGNED <i>7/21/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <i>July 27, 1955</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <i>7/24/55</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>[Signature]</i>		<i>[Signature]</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 27 1955

BUREAU V. S.

6459

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write RURAL, OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Prince Frederick</i>	
<i>X</i> TOWN <i>Pr. Frederick, Md. 3 months</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co. Hosp.</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<i>Julia C Chase</i>		<i>July 6, 1957</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>May 7, 1890</i>
9. AGE last birthday: <i>65 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>House work</i>	
11. BIRTHPLACE (State or foreign country): <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Ham Hardman</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>Unknown</i>		16. SOCIAL SECURITY No. <i>220-24-8456</i>	
17. INFORMANT'S ADDRESS: <i>Geo. F. Casper Pr. Fred, Md.</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
192X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(A) - <i>Malignant - Metastases in brain</i>			
(B) - <i>Carcinoma</i>			
(C) - <i>Sarcoma of eye (?)</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April</i> , 19 <i>55</i> , to <i>July 6, 1957</i> , that I last saw the deceased alive on <i>July 6, 1957</i> , and that death occurred at <i>7 P. M.</i> from the causes and on the date stated above.			
SIGNATURE <i>J. Williams</i>		DATE SIGNED <i>7/8/57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7/9/57</i>	
NAME OF CEMETERY OR CREMATORY <i>Bible Way Church cem.</i>		LOCATION (City, town, or county) (State) <i>Pr. Fred, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-8-57</i>		REGISTRAR'S SIGNATURE <i>N.W. Ward</i>	
24. FUNERAL DIRECTOR <i>Leroy Berry</i>		ADDRESS <i>Huntingtown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 12 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6460  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 52

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cabot</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Cabot</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<i>x</i> TOWN <i>Sancti Spiritus</i>		TOWN <i>Prince Frederick</i> <i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Raymond</i>	(Middle) <i>Edwin</i>	(Last) <i>Durall</i>	(Month) <i>July</i> (Day) <i>3</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Oct 4, 1934</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Mary</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Reserve</i>	9. AGE last birthday: <i>20</i> <i>yr</i>
11. BIRTHPLACE (State or foreign country): <i>VA</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Ashley</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Evelyn Warner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>228-42-4864</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Raymond E. Durall Prince Frederick</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
929.8 Immediate cause (a) <i>Dissection</i>			
DUE TO			
Antecedent cause(s) (b) <i>Dissection</i>			
Diseases or conditions, if any, giving rise to the above cause (c) <i>Dissection</i>			
stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>Dissection while swimming</i>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY: <i>Home, farm, factory, street, office bldg., etc.</i>	
21c. (City or town) <i>Sancti Spiritus</i> (County) <i>Cabot</i> (State) <i>MD</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>7 3 53 745 M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Dissection</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>H W Ward</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>7/14/55</i>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Removed</i>		DATE THEREOF: <i>July 7, 1955</i>	
NAME OF CEMETERY OR CREMATORY: <i>Sancti Spiritus Cemetery</i>		LOCATION (City, town, or county) (State): <i>Prince Frederick MD</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <i>James L. Hutchins</i>		24. FUNERAL DIRECTOR: <i>W. H. Hutchins</i>	
ADDRESS: <i>Prince Frederick MD</i>			

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BUREAU V. 3

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RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sunderland</u>				OR TOWN <u>Sunderland</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: 7 - 6, 1965			
(Type or Print) <u>Arthur</u>		<u>Ennis</u>					
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, (MARRIED) WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>August 11</u>	9. AGE last birthday: <u>60</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. (Seven if retired): <u>Carpenters Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Not known</u>				14. MOTHER'S MAIDEN NAME: <u>Eliza Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-4276</u>		17. INFORMANT & ADDRESS: <u>Edith Ennis Sunderland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Died sitting in a chair</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>Home</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>9:30 6 5 93 A.M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 , to 19 , that I last saw the deceased alive on 19 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Arthur Ennis</u>		M.D. <u>Owens</u>		DATE SIGNED <u>Wed 7/7/65</u>			
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>7-9-65</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Air Hope</u>		LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-9-65</u>		REGISTRAR'S SIGNATURE <u>N.W. Ward</u>		24. FUNERAL DIRECTOR <u>P.E. Sewell Prince Frederick, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 21

JUL 12 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>MD</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>N. Beach</u>				TOWN <u>N. Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
<u>Dennis Patrick Fenton Jr.</u>				<u>7 16 1953</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar</u>		8. DATE OF BIRTH: <u>July 20 1891</u>	
						9. AGE last birthday: <u>63</u> yrs.	
						IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>Police</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Police</u>			
11. BIRTHPLACE (State or foreign country): <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>Dennis P. Fenton Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Enright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>Mr D P. Fenton Jr</u>			
17. INFORMANT & ADDRESS:							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1</u> <u>Coryne disease</u>						<u>1 yr</u>	
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Found dead in bed at 9 am</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Police</u>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7 16 55 9A</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H W Ward &amp; Co</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/16/53</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF: <u>7/19/53</u>		NAME OF CEMETERY OR CREMATORY: <u>Hemp</u>		LOCATION (City, town, or county) (State): <u>Fairfax Va</u>	
DATE REC'D BY LOCAL REG. <u>7/17/53</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>Every Funeral Home</u>		ADDRESS: <u>Fairfax Va</u>	

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BUREAU V. A.

JUL 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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6463 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

Items 13, 14 Film 183 7-8-55 at

<p>1. PLACE OF DEATH:</p> <p>COUNTY <u>Cabert</u> MARYLAND</p> <p>CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u></p> <p>TOWN <u>St. Leonard</u> LENGTH OF STAY (in this place) <u>37 yrs</u></p> <p>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u></p>		<p>2. USUAL RESIDENCE (HOME) OF DECEASED:</p> <p>STATE <u>Ind</u> COUNTY <u>Cabert</u></p> <p>CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u></p> <p>TOWN <u>St. Leonard</u> STREET ADDRESS (If rural give location) <u>—</u></p>	
<p>3. NAME OF DECEASED: (First) (Middle) (Last)</p> <p><u>Nora Virginia Hardisty</u></p> <p>4. DATE OF DEATH: (Month) (Day) (Year)</p> <p><u>July 2 1955</u></p>		<p>5. SEX: <u>F</u> 6. COLOR OR RACE: <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u> 8. DATE OF BIRTH: <u>Feb. 21, 1876</u></p> <p>9. AGE last birthday: <u>79</u> yrs. <u>4</u> mos. <u>11</u> days</p>	
<p>10A. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u></p> <p>10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u></p>		<p>11. BIRTHPLACE (State or foreign country): <u>Indy - Cabert Co., Ind</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME: <u>Pitcher</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>741</u></p> <p>17. INFORMANT &amp; ADDRESS: <u>Thomas Hardisty - St. Leonard, Ind</u></p>	
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>420.1 IMMEDIATE CAUSE</p> <p>ANTECEDENT CAUSE (S)</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</p>		<p>18. MEDICAL CERTIFICATION</p> <p>(A) <u>Crohn's Disease</u> DUE TO</p> <p>(B) <u>Generalized Sclerosis</u> DUE TO</p> <p>(C) <u>—</u></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION:</p>		<p>19B. MAJOR FINDINGS OF OPERATION</p>	
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.</p>	
<p>21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)</p>		<p>20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</p>		<p>21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I hereby certify that I attended the deceased from <u>July 2</u>, 19<u>55</u>, to <u>July 2</u>, 19<u>55</u>, that I last saw the deceased alive on <u>July 2</u>, 19<u>55</u>, and that death occurred at <u>22</u> M. from the causes and on the date stated above.</p>	
<p>SIGNATURE <u>R. Williams</u></p>		<p>ADDRESS <u>St. Leonard</u> DATE SIGNED <u>7/2</u></p>	
<p>23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u></p>		<p>DATE THEREOF <u>July 4, 1955</u></p>	
<p>NAME OF CEMETERY OR CREMATORY <u>Water Memorial</u></p>		<p>LOCATION (City, town, or county) (State) <u>St. Leonard, Ind</u></p>	
<p>DATE REC'D BY LOCAL REGISTRAR <u>7/2/55</u></p>		<p>REGISTRAR'S SIGNATURE <u>N. H. Ward</u></p>	
<p>24. FUNERAL DIRECTOR <u>A. A. Harkness &amp; Son</u></p>		<p>ADDRESS <u>Method, Ind.</u></p>	



6464

## MARYLAND STATE DEPARTMENT OF HEALTH

06472

Items 7,9,14,18,21,22 Film  
158-9-13-5 amsCERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 5

1. PLACE OF DEATH COUNTY <b>Calvert</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Calvert</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN Chesapeake Beach</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Chesapeake Beach (bay)</b>		STREET ADDRESS <b>(If rural, give location)</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>GLADYS</b> (Middle) <b>HINES</b> (Last)		(Month) <b>July</b> (Day) <b>30</b> (Year) <b>1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct 7, 1926</b>
9. AGE last birthday <b>25 28</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Prince Georges</b>	
11. BIRTHPLACE (State or foreign country) <b>Prince Georges</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wm. C. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Huffman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <b>Frances Hines</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<b>9/55</b> Immediate cause (a) <b>Drowning</b> Antecedent cause(s) (b) <b>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</b> (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION		
19b. MAJOR FINDINGS OF OPERATION		21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
PLACE (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>		
TIME (Month) (Day) (Year) (Hour) <b>July 30 1955 P m.</b>		(CITY OR TOWN) <b>Chesapeake Beach</b> (COUNTY) <b>Calvert</b> (STATE) <b>Md.</b>
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <b>Waded into water- found floating face down</b>

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE **Ass't. Medical Examiner-700 Fleet St.-Balto. 2, Md. 7/30/55** DATE SIGNED

23. FINAL CREMATION OR BURIAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>July 31, 1955</b>	<b>Mt. Harmony</b>	<b>Owings, Calvert, Md.</b>	
24. FUNERAL DIRECTOR		ADDRESS		
<b>W. H. Hutchins</b>		<b>Calvert County</b>		

MARGIN RESERVED FOR BINDING

USE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.



# THE MORGUE

10-1-10

08474

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6465

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Adelina</u>		<u>Life</u>		OR TOWN <u>Adelina</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH.			
First (Middle) (Last) <u>Samuel G. Hooper</u>				<u>July 10, 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>D</u>	8. DATE OF BIRTH: <u>Sept. 9, 1875</u>	9. AGE last birthday (If under 1 year)	10. MONTHS	11. DAYS	12. HOURS
				<u>79</u> yrs	<u>10</u>	<u>1</u>	<u>1</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired)				11. BIRTHPLACE (State or foreign country)			
<u>Crysmen</u>				<u>Calvert County Ind. U.S.A.</u>			
13. FATHER'S NAME: <u>Alexander Hooper</u>				14. MOTHER'S MAIDEN NAME: <u>Mrs. Francis Buckmaster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
<u>No</u>				<u>Mrs. John W. Hooper - Adelina, Ind.</u>			
16. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE				(A) <u>Cholelithiasis</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>arteriosclerosis</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
				<u>M.</u>			
22. I hereby certify that I attended the deceased from <u>4/1, 1950</u> to <u>7/10, 1955</u> , that I last saw the deceased <u>alive on 7/6, 1955</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u>							
DATE SIGNED <u>7/10/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Central Cemetery, Baston - Calvert Co - Ind.</u>			
DATE REC'D BY LOCAL REGISTRAR				24. FUNERAL DIRECTOR			
<u>7-12-55</u>				<u>C. A. Harkness &amp; Son - Martel, Ind.</u>			
REGISTRAR'S SIGNATURE				ADDRESS			
<u>N. W. Ward</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06475

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert 6</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>St. Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> OR TOWN STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED: (Type or Print) <u>Henry</u> (First) <u>Lust</u> (Middle) <u>Lust</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>9</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7/10/1884</u>
9. AGE last birthday <u>70</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired. <u>Police Officer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Police</u>	
11. BIRTHPLACE (State or foreign country): <u>NY C</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Isaac Lust</u>		14. MOTHER'S MAIDEN NAME: <u>Julia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT'S ADDRESS: <u>Mrs. Henry Lust Upper Marlboro Md</u>			
15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary disease</u> DUE TO ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Was taken with an attack &amp; died</u>		6 yrs	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY <u>Home</u> office, bldg., etc)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Upper Marlboro Md</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> . SIGNATURE <u>H W Wand P M 3</u> ADDRESS <u>Upper Marlboro</u> DATE SIGNED <u>7/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington Heb</u>		LOCATION (City, town, or county) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-9-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Wand</u>	
FURNERAL DIRECTOR <u>13 Hanson &amp; Son</u>		ADDRESS <u>3501 E 14th St NW Wash DC</u>	





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06476

6467

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Frederick</u>	<u>6 wks</u>	OR TOWN	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	<u>1</u>
64	<u>Calvert Co Hospital</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: <u>7/15/55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
			9. AGE last birthday: <u>74</u> yrs. Months Days Hours Mks.
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>retiree</u>	<u>Frederick</u>	<u>Calvert Co, Md.</u>	<u>U.S.A.</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	17. INFORMANT & ADDRESS:	
<u>John S. Cunningham</u>	<u>John F. Cunningham</u>	<u>Frederick, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	18. MEDICAL CERTIFICATION	
		1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
IMMEDIATE CAUSE		(A) <u>Carcinoma of colon</u>	
ANTECEDENT CAUSE (B)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) DUE TO	
		(C)	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>6/8/55</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/8/55</u> , to <u>7/14/55</u> , that I last saw the deceased <u>alive on 7/4/55</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>buried</u>		<u>7/16/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Frederick</u>		<u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>7/16/55</u>		<u>Frederick, Md.</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: COUNTY Calvert MARYLAND CITY Port Republic OR TOWN Port Republic LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS Bedford 2000 Rodda

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Va COUNTY Richmond CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Richmond STREET ADDRESS (If rural give location) Va

3. NAME OF DECEASED: (First) (Middle) (Last) Richard Thomas Rodda

4. DATE (Month) (Day) (Year) OF DEATH: 7 5 1955

5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M 8. DATE OF BIRTH: June 18, 1908 9. AGE last birthday: 46 yrs. 10. UNDER 1 YEAR: Months Days Hours Mln. 11. UNDER 24 HRS. Months Days Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician 10B. KIND OF BUSINESS OR INDUSTRY: Ward for July 11. BIRTHPLACE (State or foreign country): West Va 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Rodda 14. MOTHER'S MAIDEN NAME: Bessie Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS: Gilbert Rodda

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

914.8 IMMEDIATE CAUSE (A) Electrocuted DUE TO

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Was using an elec. sander on a boat

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 21B. PLACE (Home, farm, factory, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) Richmond Richmond Va

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 7 5 55 P 21E. INJURY OCCURRED While ☒ Not while ☐ at work at work 21F. HOW DID INJURY OCCUR? Was using an elec. sander on a boat

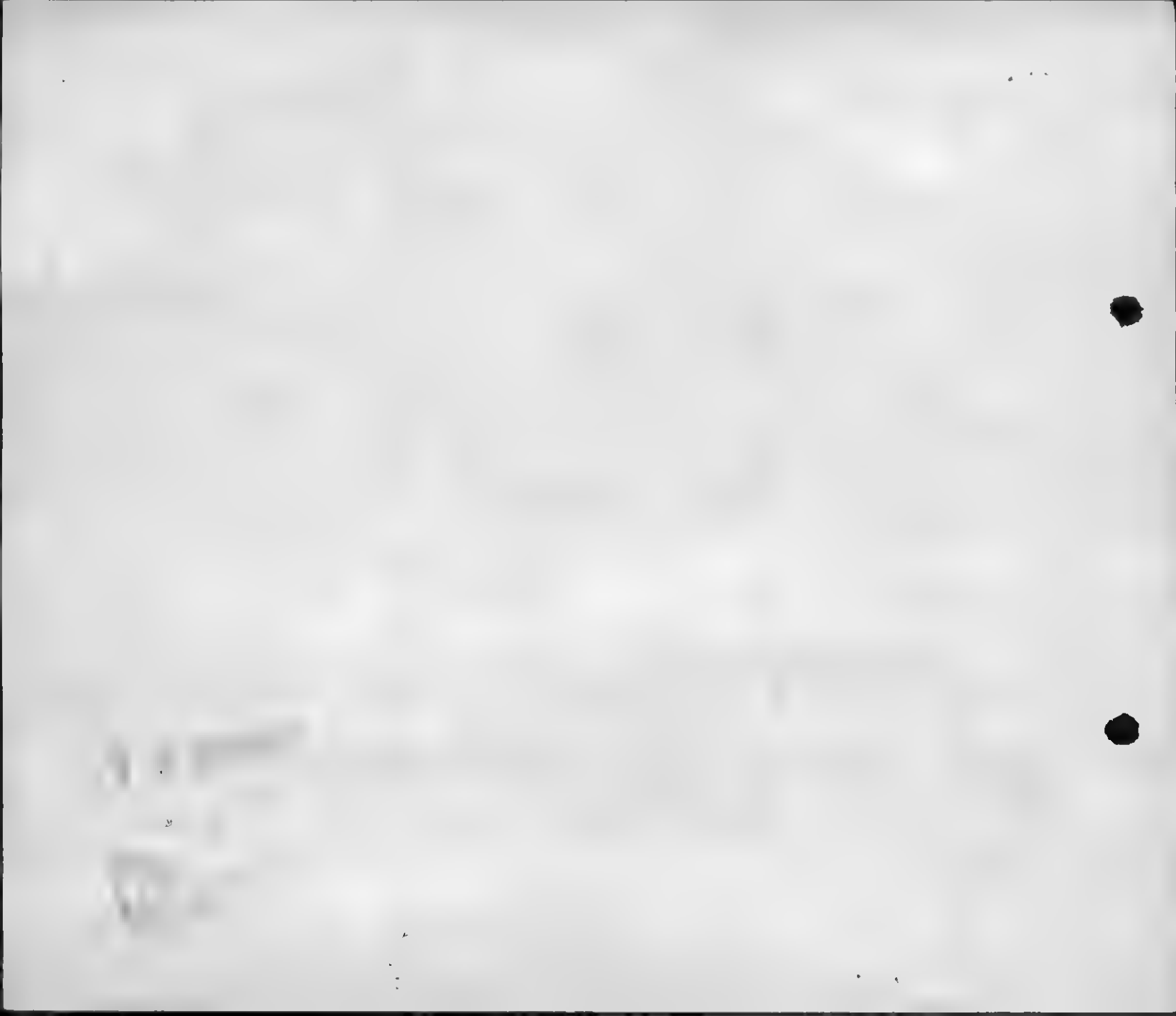
22. I hereby certify that I attended the deceased from 19, to 19, that I last saw the deceased alive on 7/5/55, and that death occurred at Richmond, Va M. from the causes and on the date stated above. SIGNATURE W. W. Ward ADDRESS Wm. Remount & Son DATE SIGNED 7/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried DATE THEREOF 7/7/55 NAME OF CEMETERY OR CREMATORY Longfellow LOCATION (City, town, or county) (State) Calvert Va

DATE REC'D BY LOCAL REGISTRAR 7-5-55 REGISTRAR'S SIGNATURE W. W. Ward 24. FUNERAL DIRECTOR, ADDRESS Wm. Remount & Son

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No.

51

6463

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>MO.</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>PRINCE FREDERICK</u>		<u>4 DAYS</u>		<u>HUNTINGTOWN, MO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ROSIE</u> <u>WOOD</u>				<u>July 25, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>W</u>	<u>FEB 28 1862</u>	<u>93</u> yrs.	Months <u>4</u> Days <u>27</u>	Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Calvert Co. MO.</u>		<u>W. S. A.</u>	
13. FATHER'S NAME: <u>GEORGE BOWEN</u>				14. MOTHER'S MAIDEN NAME: <u>ANN BUCK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Yes</u>				16. SOCIAL SECURITY NO. <u>MO</u>		17. INFORMANT & ADDRESS: <u>MRS. W.M. B. BOWEN, HUNTINGTOWN, MO</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <u>arteriosclerosis</u>							
DUE TO							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>51</u> , to <u>7/25</u> , 19 <u>55</u> , that I last saw the deceased <u>alive</u> , 19 <u>    </u> , and that death occurred at <u>M, from the causes and on the date stated above.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>July 27, 1955</u>		<u>Arboretum Cemetery</u>		<u>Baltimore - Calverton, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 29, 1955</u>		<u>W.H. Hardy</u>		<u>G.G. Harkness &amp; Son - Mount Airy, Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. 8

JUL 29 1955

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. 06479

No. 52

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
X TOWN <u>Huntington</u>		<u>Huntington</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		/	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Carlton Edward Young</u>		<u>7 3 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>24-13-1944</u>
9. AGE last birthday: <u>11</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:	
<u>Student</u>			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edward Young</u>		14. MOTHER'S MAIDEN NAME: <u>Evelyn E. Ashby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>	
<u>—</u>		17. INFORMANT & ADDRESS: <u>Edward Young Huntington</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Drown</u>		
DUE TO		
Antecedent cause(s) (b)		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Was sewing &amp; down</u>		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office, bldg., etc., INJURY)	21c. (City or town) (County) (State)
	<u>Huntington Calvert MD</u>	<u>MD</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7 3 55 1300</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>rowning</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
SIGNATURE <u>H. W. and</u>	DATE SIGNED <u>7/14/55</u>
CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>	DATE THEREOF: <u>July 6, 1955</u>	NAME OF CEMETERY OR CREMATORIUM: <u>Lesley Cemetery</u>	LOCATION (City, town, or county) (State): <u>Prince Frederick MD</u>
DATE REC'D BY LOCAL REG. <u>July 5, 1955</u>	REGISTRAR'S SIGNATURE: <u>Grace L. Hutchins</u>	24. FUNERAL DIRECTOR: <u>Wm. H. Hutchins</u>	ADDRESS: <u>Durings road</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

11 1955

RECEIVED